GIC Employees/Retirees without Medicare

HMO Summary of Benefits Chart

This chart provides a summary of key services offered by your Health New England plan. Consult your Member Handbook for a full description of your plan's benefits and provisions. If any terms in this summary differ from those in your Member Handbook, the terms of the Member Handbook apply.

Please read "Important Information about copay tiers." If you change your specialist, your copay may change.

Medical Deductible

- For some services, members are responsible for meeting a Policy Year Deductible before the plan pays benefits. This deductible is: **$400 per individual Member / $800 per family**.
- **You must pay any Copay or Coinsurance for a service**. If the deductible applies to that service, you must pay the difference between your Copay or Coinsurance amount and the amount of Health New England's contracted payment to the provider until the Policy Year Deductible is satisfied.
- The chart below shows whether or not this deductible applies. **Important Note:** Ancillary services such as tests and procedures performed during an office visit may be subject to the deductible, even if the visit itself is not subject to the deductible.
- The deductible does not apply to prescription drugs.

Prescription Drug Deductible

- You pay all costs for prescription drugs from an authorized pharmacy until you reach a deductible of $100 per individual member or $200 per family.
- After you reach your prescription drug deductible, for the rest of the year you will only have to pay the Copays. Each copay is for up to a 30-day supply of prescription drugs from an authorized pharmacy or a 90-day supply of maintenance medications from an authorized pharmacy or through mail order.
- The Deductible for prescription drugs is separate from the deductible your plan has for medical services.
- Prescription Drug Benefits are administered by CVS Caremark.

In-Network Medical Out-of-Pocket Maximum

- The out-of-pocket maximum includes copays, coinsurance and deductible for all in-network medical services including pharmacy and behavioral health. Once you have met the out-of-pocket maximum, you will not have to pay copays or coinsurance for these services for the rest of the policy year.
- The out-of-pocket maximum is **$5,000 per individual member / $10,000 per family.**

BENEFIT	Deductible Applies	Copay
Inpatient Care		
Acute Hospital Care	Yes	$275/admission † ‡
Inpatient Rehabilitation	Yes	$275/admission †
Skilled Care Facility *(maximum of 100 days per Policy Year)*	Yes	$0

† Maximum of one inpatient admission Copay per quarter.

‡ If you have paid an inpatient Copay for an admission and are then readmitted to a hospital within 30 calendar days of discharge from the previous admission, the Copay for the readmission is waived if both admissions occur during the same Policy Year. See your Member Handbook for details.

BENEFIT	Deductible Applies	Copay
Outpatient Preventive Care		
Adult Routine Physical Exams by your PCP	No	$0
Pediatric Preventive Care	No	$0
Annual Gynecological Exam	No	$0
Screening Mammographic Exam	No	$0
Medically Necessary Adult and Child Immunizations by your PCP	No	$0
Screening colonoscopy	No	$0
Nutritional Counseling	No	$0/visit for first four visits, then $20/visit
Other Outpatient Care		
PCP Office Visits	No	$20/visit
Specialist Office Visits	No	Tier 1: $30/visit Tier 2: $60/visit
Second Opinions	No	Tier 1: $30/visit Tier 2: $60/visit
Telephone and video consultations with internists, family practitioners, pediatricians, behavioral health and urgent care services for non-emergency medical conditions through Teladoc™ *(The first three behavioral health visits have no cost, and then regular member cost share applies.)*	No	$20/consultation $0/visit for first three behavioral health consultations
Routine Eye Exams *(one each 24 months)*	No	$20/visit
Hearing Tests in your PCP's office	No	$20/visit
Diabetic-Related Items		
Endocrinology Specialist Office Visits	No	Tier 1: $30/visit Tier 2: $60/visit
Laboratory/Radiological Services	Yes	$0
Durable Medical Equipment *(diabetic-related; some items require Prior Approval)*	No	$0 + 20% Coinsurance
Individual Diabetic Education	No	$20/visit
Group Diabetic Education	No	$20/session
Applied Behavioral Analysis (ABA) to treat Autism Spectrum	No	$0
Urgent Care Center or retail clinic visits	No	$20/visit
Emergency Room Care *(Copay waived if admitted directly from ER)*	Yes	$100/visit

BENEFIT	Deductible Applies	Copay
Diagnostic Testing ***(some services may be subject to the Outpatient Surgical Services and Procedures copay. Not all services are subject to a copay.)***		
In a PCP's Office	Yes	$20/visit
In a Specialist's Office	Yes	Tier 1: $30/visit Tier 2: $60/visit
In All Other Settings	Yes	$150/visit for freestanding ASC facilities (GI/Eye Procedures Only) $250/visit for hospital outpatient facilities §
Laboratory Services	Yes	$0
Radiological Services: Ultrasound, X-rays, Nuclear Cardiology (*Nuclear Cardiac Imaging requires Prior Approval*)	Yes	$0
Advanced Diagnostic Imaging: CT Scans, MRIs, MRAs, PET Scans *(requires Prior Approval)*	Yes	$100/visit (maximum one copay per day)
Outpatient Short-Term Rehabilitation Services *(Physical and occupational therapy; covered for 90 days per acute episode, per Policy Year. The limit does not apply when services are provided to treat Autism Spectrum Disorder.*)	No	$20/visit/treatment type
Day Rehabilitation Program *(limited to 15 full day or half day sessions per condition per lifetime)*	No	$20/day or half day
Early Intervention Services *(covered for children from birth to age 3)*	No	$0
Outpatient Surgical Services and Procedures *(some services require Prior* ***Approval****)*		
In a PCP's Office	No	$20/visit
In a Specialist's Office	No	Tier 1: $30/visit Tier 2: $60/visit
All Other Settings	Yes	$150/visit for freestanding ASC facilities (GI/Eye Procedures Only) $250/visit for hospital outpatient facilities §

§ Maximum of four outpatient surgery Copays per Policy Year.

BENEFIT	Deductible Applies	Copay
Allergy Testing and Treatment in an Allergist's Office	No	Tier 1: $30/visit Tier 2: $60/visit; $0 for injection
Infertility Services *(Some infertility treatments require Prior Approval. Some Assisted Reproductive services consist of outpatient surgical procedures. If members receive these services applicable outpatient surgical services and procedures Copays will apply.)*		
Office Visits *(Deductible may apply to some office services)*	No	Tier 1: $30/visit Tier 2: $60/visit
Outpatient Care	Yes	Tier 1: $30/visit Tier 2: $60/visit
Laboratory Tests	Yes	$0
Inpatient Care	Yes	$275/admission † ‡
Maternity Care		
Routine Prenatal and Postpartum Care	No	$0
Delivery/Hospital Care for Mother and Child *(Coverage for child limited to routine newborn nursery charges. For continued coverage, child must be enrolled within 30 days of date of birth.)*	Yes	$275/admission † ‡
Dental Services		
Surgical Treatment of Non-Dental Oral Conditions and Emergency Dental Care		
In a Specialist's Office	Yes	Tier 1: $30/visit Tier 2: $60/visit
At an Emergency Room	Yes	$100/visit
Hospital Inpatient	Yes	$275/admission † ‡
Outpatient Surgical Facility	Yes	$250/visit §
Other Services		
Home Health Care *(requires Prior Approval)*	Yes	$0
Hospice Services	Yes	$0
Durable Medical Equipment *(some items require Prior Approval)*	Yes	20% Coinsurance
Prosthetic Equipment *(requires Prior Approval)*	Yes	$0
Scalp Hair Prostheses (Wigs) for hair loss due to treatment of any form of cancer or leukemia (*Health New England covers one prosthesis per Policy Year)*	No	$0
Emergency Ambulance and Chair Van Services	Yes	$0 after deductible

† Maximum of one inpatient admission Copay per quarter.

‡ If you have paid an inpatient Copay for an admission and are then readmitted to a hospital within 30 calendar days of discharge from the previous admission, the Copay for the readmission is waived if both admissions occur during the same Policy Year. See your Member Handbook for details.

§ Maximum of four outpatient surgery Copays per Policy Year.

BENEFIT	Deductible Applies	Copay
Non-Emergency Ambulance and Chair Van Services *(requires Prior Approval)*	Yes	$25/member/day
Reconstructive or Restorative Surgery	Yes	$275/admission † ‡
Kidney Dialysis	No	$0
Human Organ Transplants and Bone Marrow Transplants *(requires Prior Approval)*	Yes	$275/admission † ‡
Nutritional Support *(requires Prior Approval)*	Yes	$0
Cardiac Rehabilitation	No	$20/visit
Speech, Hearing, and Language Disorders *(requires Prior Approval after the initial evaluation)*	No	$20/visit
Coronary Artery Disease Program *(Provided for members with documented coronary artery disease, this program helps participants reduce coronary artery disease risk factors through lifestyle changes. The program must be authorized by your PCP.)*	Yes	10% Coinsurance
Hearing aids		
• Members 21 and under *(Health New England covers the cost of one hearing aid per hearing impaired ear, every 24 months, up to a maximum of $2,000 for each hearing aid. Prior Approval is required.)*	No	100% coverage up to $2,000 per device per ear (you are responsible for all costs beyond maximum)
• Members over 21 years' old *(Health New England will reimburse for the purchase or repair of hearing aids for each ear at 100% per person, up to a maximum of $1,700, **every two Policy Years.**)*	No	100% coverage for the first $1,700 each ear, per person, every two Policy Years
Behavioral Health Services (Behavioral Health and Substance Abuse) *(Some services may require Prior Approval)*		
Inpatient Services *(Some inpatient admissions may require Prior Approval)*	Yes	$0
Intermediate Services *(such as Partial Hospitalization)*	Yes	$0
Outpatient Services	No	$20/visit
Chiropractic Care		
Chiropractic Care (see Chiropractic Rider for coverage details) *(children under age 13 require Prior Approval)*	No	$20/per visit

† Maximum of one inpatient admission Copay per quarter.

‡ If you have paid an inpatient Copay for an admission and are then readmitted to a hospital within 30 calendar days of discharge from the previous admission, the Copay for the readmission is waived if both admissions occur during the same Policy Year. See your Member Handbook for details.

Chiropractic Services Benefit **HMO** **Office Visit Copay: $20**	
This benefit is administered by OptumHealth Care Solutions, Health New England's chiropractic services manager.	
What your plan covers	• We cover up to 20 visits per plan year for medically necessary chiropractic services. • When you receive services, your In-Plan chiropractor must notify OptumHealth Care Solutions. OptumHealth Care Solutions will work with your In-Plan chiropractor to determine the appropriate level of covered services to treat your condition. If your chiropractor does not notify OptumHealth Care Solutions, the service will not be covered. • We will cover your visits with an In-Plan chiropractor. A $20 Copay applies for each visit.
For more information or to find a provider	*On the web:* You can find information about OptumHealth participating chiropractors through our web site. • Go to healthnewengland.org/provider-search • Go down to "Find a Chiropractic Provider" and click Search *On the phone:* • Call Health New England Member Services at (413) 787-4004 or (800) 310-2835 • Call OptumHealth Care Solutions at (888) 676-7768